## Family Center for Children and Youth with Special Health Care Needs



# 2022 Camp Scholarship Application



Parents/Caregivers of a child or youth with special health care needs are encouraged to apply for up to \$250 for a Camp Scholarship from the Family Center for Children and Youth with Special Health Care Needs (Family Center). The scholarship program has limited funding available, so submit your application as soon as possible.

### WHO MAY BE ELIGIBLE?

Applicants are eligible for the Camp Scholarship once every 2 years, and one Camp Scholarship per family. Camper must be between the ages of 5-21

Applications are accepted January 1, 2022 through March 31, 2022. Children and youth with special health care needs are eligible regardless of their enrollment with Children's Special Health Care Services (CSHCS). Scholarship receipts must participate in a camp between January 1, 2022 through September 30, 2022.

**Camp Guidelines**: The camp must be in Michigan and have a camp license. The camper must reside in Michigan at the time of applying and attending the camp. Camps scholarships are not just limited to face to face camps, virtual camps are considered as well.

Exceptions: Camps operated by a <u>university</u>, <u>school district</u>, or <u>city/township parks and recreation</u> program, are not required to have a camp license.

## PARENTS/CAREGIVERS ARE RESPONSIBLE FOR THE FOLLOWING:

- 1. <u>FINDING THE CAMP FOR YOUR CHILD TO ATTEND (the Family Center does not maintain a list of camps):</u> The camp must be able to accommodate your child's special health care needs.
- 2. <u>REGISTERING YOUR CHILD WITH THE CAMP</u>: The Camp must fill out the attached <u>Attendance</u> Registration form. This form must be submitted with your Camp Scholarship Application.
- 3. COMPLETING THE ATTACHED CAMP SCHOLARSHIP APPLICATION.

Mail or fax (preferred method) the Camp Application and the completed attendance confirmation form to:

Family Center Michigan Department of Health and Human Services P.O. Box 30734 Lansing, MI 48909

Fax number 517-241-8970

#### **SCHOLARSHIP AWARD NOTIFICATION**

Scholarships from the Family Center are not guaranteed until the camp and the child's parent/caregiver(s) receive an approval letter from the Family Center confirming the camp scholarship. The scholarship check from the Family Center will be issued directly to the camp. If there is any remaining camp tuition balance, the parent/caregiver is responsible for paying that amount directly to the camp. The Family Center will not reimburse parent/caregiver for a payment already made to a camp, including any deposit.

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## Family Center for Children and Youth with Special Health Care Needs

# 2022 Camp Scholarship Application

Any questions can be answered by calling the Family Phone Line at 800-359-3722 APPLICATION FORM AND INFORMATION

(Applicants are eligible for the Camp Scholarship once every 2 years.)

| Date  | Scholarship Amount Requeste        | d (up to \$250.00) \$ |  |  |
|---|------------------------------------|-----------------------|--|--|
| Child's Name  | DOB                                | CSHCS/Medicaid<br>ID# |  |  |
| Parent/Caregivers Name  | Phone # ()                         |                       |  |  |
| Street Address  | City, State, Zip                   |                       |  |  |
| County  | -                                  |                       |  |  |
| Childs Diagnosis  |                                    |                       |  |  |
| Name of the Camp Your Child Would Like to Attend  | 1                                  |                       |  |  |
| REQUIRED CAMP INFORMATION   |                                    |                       |  |  |
| <ul> <li>Parents/Caregivers are responsible for reg</li> <li>Camp Attendance Registration form must l</li> <li>Camps must be licensed and located in Mid</li> </ul> | pe submitted with this application | •                     |  |  |
| APPLICATION CHECKLIST  Complete the 2022 Camp Scholarship Appli Include with this application a completed At  |                                    | this application.     |  |  |
| MAIL OR FAX (preferred method) THIS APPLICATION   | AND ATTENDANCE CONFIRMAT           | ION FORM TO:          |  |  |
| Family Center Michigan Department of Health and Human P.O. Box 30734  | Services                           |                       |  |  |
| Lansing, MI 48909   |                                    |                       |  |  |
| Fax number 517-241-8970   |                                    |                       |  |  |
| PARENT/CAREGIVERS SIGNATURE (REQUIRED)  |                                    |                       |  |  |
|   | Dat                                | te                    |  |  |

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# **Attendance Registration**

The Camp Director or Registrar must complete this form.

# CAMPER REGISTRATION INFORMATION \*\*PLEASE MAKE SURE THIS FORM IS SENT IN WITH THE APPLICATION \*\*

| Camper's Name   |  |   | has registered for<br>Camp Name                              |   |                                |                   |
|---|--|---|--|---|--------------------------------|-------------------|
| from<br>Date  | _through                                 | Date  | The cost for   | attending th                            | is camp is \$_                 | <br>Amount        |
| The family has paid \$_   |  | toward that   | cost and the amou  | ınt due is                              |                                |                   |
| The failing has paid \$\frac{1}{2}\$  | Amount                                   | toward tride (  | cost and the amor  | int duc 13                              | Amount                         | - <b>·</b>        |
| CAMP INFORMATION  |  |   |  |   |                                |                   |
| Camp Name –<br>(Official camp name that<br>should go on check)  |  |   |  |   |                                |                   |
| Camp Address<br>(Where check is to be<br>mailed)  |  |   |  |   |                                |                   |
| City, State, Zip Code   |  |   |  |   |                                |                   |
| Federal Tax ID Number   | er ——                                    |   |  |   |                                |                   |
| Camp License Number   | r  |   |  |   |                                |                   |
| Contact Name  |  |   |  |   |                                |                   |
| Contact Phone Number  | er                                       |   |  |   |                                |                   |
| understand a scholars approval letter from the exceed \$250.00. The punderstand a check will certify that the above | e Family C<br>parent/care<br>I be issued | enter. The legiver of the contraction directly to the | tter will indicate t<br>amper is respons<br>e camp to pay fo | he amount of the for paying the scholar | of the scholar<br>ng any remai | ship and will not |
| SIGNATURE OF CAMP D   | DIRECTOR/                                | REGISTRAR (J  | REOUIRED)  | •                                       |                                |                   |
|   |  |   |  |   |                                |                   |

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cshcsfc@michigan.gov.

Michigan Department of Health and Human Services (MDHHS)
Please note if needed, free language assistance services are available.
Call 800-359-3722 (TTY users call 711).

| Spanish           | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia   |
|-------------------|--|
|                   | lingüística. Llame al 800-359-3722 (TTY: 711).   |
| Arabic            | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 3722-359-800 (رقم هاتف   |
|                   | الصم والبكم:-711:TTY).   |
| Chinese           | 注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 800-359-3722(   |
|                   | TTY:711)   |
| Syriac (Assyrian) | رومة كالمرتكة من المراقة من المراقة المراقة المراقة المراقة المراقة المراقة المرتكة المراقة ال |
|                   | جَل جِنتِكَ، (TTY:711) 800-359-3722 (TTY:711)  |
| Vietnamese        | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho  |
|                   | bạn. Gọi số 800-359-3722 (TTY:711).  |
| Albanian          | KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës   |
|                   | gjuhësore, pa pagesë. Telefononi në 800-359-3722 (TTY:711).  |
| Korean            | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-  |
|                   | 359-3722 (TTY:711)번으로 전화해 주십시오.  |
| Bengali           | লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা  |
|                   | উপলব্ধ আছে। ফোন করুন ১-800-359-3722 (TTY ১-711)  |
| Polish            | UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy  |
|                   | językowej. Zadzwoń pod numer 800-359-3722 (TTY:711).   |
| German            | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche   |
|                   | Hilfsdienstleistungen zur Verfügung. Rufnummer 800-359-3722 (TTY:711).   |
| Italian           | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di  |
|                   | assistenza linguistica gratuiti. Chiamare il numero 800-359-3722 (TTY:711).  |
| Japanese          | 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。800-359-3722   |
|                   | (TTY:711)まで、お電話にてご連絡ください   |
| Russian           | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные  |
|                   | услуги перевода. Звоните 800-359-3722 (телетайп 711).  |
| Serbo-Croatian    | OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su  |
|                   | vam besplatno. Nazovite 800-359-3722 (TTY Telefon za osobe sa oštećenim  |
|                   | govorom ili sluhom 711).   |
| Tagalog           | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga  |
|                   | serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-359-3722 (TTY:  |
|                   | 711).  |

1/3/2022 PAGE: 4 The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Oualified interpreters
  - o Information written in other languages

If you need the above services, contact the MDHHS Section 1557 Coordinator.

If you believe that MDHHS has failed to provide the above services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: MDHHS Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the MDHHS Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator Compliance Office, 4<sup>th</sup> Floor P.O. Box 30195 Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax), MDHHS-ComplianceOffice@michigan.gov

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://bit.ly/2IKsHMS.

If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by:

Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all information requested in the form.

To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410

Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.

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